

**California Radiological Society
Annual Report to the Membership**

Submitted by

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Prepared for

**Members of the
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CALIFORNIA RADIOLOGICAL SOCIETY

2008-2009 ANNUAL REPORT TO THE MEMBERSHIP

Welcome to the 2009 CRS Annual Business Meeting. The Annual Report is presented to the membership as a highlight of the major issues CRS has addressed over the past year. Socioeconomic issues impacting diagnostic and interventional radiology and radiation oncology practice remains our focus. The Society continues to interact with California legislators, relevant regulatory agencies, payers, and colleagues in an effort to shape those issues.

I. LEGISLATIVE ISSUES

Bill Defining Entities Contracting for Imaging Services

As a result of the adoption of CRS sponsored AB 2374 (Blakeslee) regarding sham lease arrangements for imaging, there was legislation introduced that sought to clarify the definition of “third party payer” for purposes of the direct billing requirement. You will recall that AB 2374, which took effect on 1/1/09, requires that the imaging facility that provides the technical component of MRI, CT or PET must directly bill the patient or his/her third party payer with some exceptions.

AB 1190 (Niello) was sponsored by self-insured employers who sought to include entities that contract with an employer or insurer to arrange for the provision of diagnostic imaging services to the definition of third party payer. The CRS is aware of entities that contract with imaging facilities on a negotiated fee schedule and provide a network of imaging facilities to an insurer or self-insured employer at a discount from the Workers’ Compensation fee schedule for those imaging procedures. There are legal issues as to how these entities may be structured and whether they can mark-up the providers charge or profit from the provision of medical services.

When AB 1190 was heard in the Assembly we raised those issues and sought amendments to insure that such arrangements did not violate the prohibition on the corporate practice of medicine or the ability to profit from the referral of patients for medical services. The author and sponsors resisted our suggestions and the bill moved to the Senate. The bill was set but not heard in the Senate Health Committee in July and thus is also on a two year status and can be heard next year. The Committee analysis pointed out the same concerns that we had raised and suggested amendments to deal with those issues.

In a related development there was an opinion issued by the California Attorney General in September that impacts the questions raised regarding entities that contract to provide imaging services through a network. The question presented to the A. G. related to Medical Provider Network under Workers Compensation and whether an individual or entity who is not licensed to practice medicine may perform professional radiology services for a Medical Provider Network.

Under Workers Compensation and MPN is a network of physicians who are pre-designated to provide treatment to injured workers. The question posed was whether a lay entity could contract with an MPN to provide radiology services. The A.G. concluded that they could not under the ban on the corporate practice of medicine. The opinion also concluded that professional radiology services, specifically including the selection of the suitable radiologist, selection of the suitable imaging facility with appropriate equipment and personnel, as well as preparing and interpreting radiological images, do involve the exercise of medical judgment as part of the practice of medicine.

This opinion is consistent with some prior A. G. opinions in this area and supports the CRS concerns that some of these lay entities that contact with insurers or self insured employers to provide imaging services

through a network of imaging centers may be in violation of California law. To the extent that these entities choose the providers and bill for their services they, under this opinion, are effectively practicing medicine.

Balance Billing By Non-Contracted Hospital Based Physicians for Emergency Services

In January the California Supreme Court issued a unanimous decision in the Prospect Medical Group case involving non-contracted hospital emergency room physicians and a delegated medical group. The Medical Group argued that there was an “implied” contract between the emergency room physician and the HMO enrollee in the case of emergency services that prohibited the ER physician from balance billing and requires them to seek any payment recourse from the plan or delegated medical group. The Court agreed and concluded that the dispute over the level of payment had to be resolved between the physician and the plan or delegated medical group. This decision only applies to emergency services in the hospital setting but does apply to anyone other than ER physicians.

Also late last year the Department of Managed Health Care (DMHC) filed a third version of a regulatory package that would ban the ability of non-contracted hospital based physicians to balance bill enrollees of plans or delegated medical groups that have contracts with their hospitals. It would apply to emergency services and would define balance billing as an unfair billing practice. This regulation version would ban balance billing and establish an arbitration system, but with no interim payment standard. The regulation took effect on October 15, 2008. A legal challenge to the authority of DMHC to issue the regulation was not successful.

Recently the DMHC has sent a letter to all its regulated health plans and their delegated medical groups seeking information on their rate methodologies for non-contracted hospital based physicians providing emergency services in the hospital setting. It also asked if those reimbursement rates have been altered during the last six months. It is believed that DMHC is gathering this information to be better positioned to arbitrate a reimbursement dispute and to perhaps establish some benchmark as to what is “reasonable “ payment for plans and delegated medical groups. The data is to be collected in October. We will keep you informed on developments in this area.

Use of Ionizing Radiation Legislation

We previously informed you of legislation introduced this year which deals with the ability to use ionizing radiation and who can supervise an RT or other type of practitioner.

Current law provides for licensing and regulation of ionizing radiation equipment used for medical purposes and certifies various types of health care practitioners for its application and use. There are two bills introduced that make changes to current requirements for practitioners who are not certified/permited as RTs or limited permit technologists.

AB 356 (Fletcher) - would allow a Physician Assistant to sit for the exam as an Operator/Supervisor and allow them to use ionizing radiation and fluoroscopy within their scope of practice and under the supervision of a physician who also possesses an Operator/Supervisor permit.

The CRS worked with the sponsors and the CSRT to limit this bill to fluoroscopy only and to require evidence of sufficient training before being able to sit for the BRH program. A Physician Assistant must complete 40 hours of coursework, including fluoroscopy radiation safety and protection, recognized by the Department. The PA must be supervised by a physician that also has a fluoroscopy permit. We did not believe their training and experience with ionizing radiation and radiation safety is sufficient with passage of a short test on the subject matter. Those narrowing amendments were obtained in the Assembly. The CRS was neutral on the amended version of AB 356.

AB 356 is on the Governor's desk and should be signed. It would take effect on 1/1/10 subject to the BRH completing the administrative requirements such as application form and the like.

The CRS continues to believe that the creation of a license category in California for a Radiologist Assistant is the best solution to providing the radiology community with the support they need to improve efficiency. We did not sponsor legislation this year to create that category since the state cost to implement any new license category would have been a barrier to progress this year. We had requested that the Radiologic Technology Certification Committee (RTCC) include this as an issue for discussion at their September 23rd meeting. We will continue to explore legislative and regulatory options in the future.

AB 445 (Salas) - would amend the current law regarding the use and supervision of fluoroscopy. It would allow the use of a mini C-arm digital radiography device to diagnose bone fractures in a trauma center or hospital ER by an orthopedic resident, orthopedic nurse practitioner, or physician assistant while under the direct or indirect supervision of an RT. This is sponsored by San Diego Children's Hospital who claims that they can't find a radiologist or qualified fluoroscopy supervisor in after hour's situation and that this procedure is being done in the ER. The CRS opposes this bill as introduced due to the dangers of inappropriate use of fluoroscopy equipment and the need for appropriately trained individuals. We have had conversations with the sponsor and author. The bill was not heard this year and is thus a two year bill that could be taken up next January.

Screening Mammography for Every Woman Counts (EWC) Program

The EWC is part of the Breast and Cervical Cancer Early Detection Program which is funded in part by CDC dollars and from Prop 10 tobacco tax dollars. It provides education, screening, and therapeutic services for low income women who are not Medi-Cal eligible. The CRS has been participating in discussions with the EWC program and within the Legislature on issues related to digital mammography.

The EWC has not been covering digital mammography due to the fact that CDC did not see the cost benefit of digital for all women over analog mammography and lack of adequate dollars to pay the higher cost. The former issue has been resolved since CDC has changed their policy. Lack of financial resources for EWC to pay a cost differential for digital vs. analog, e.g. the way Medi-Cal and Medicare do, has unfortunately not been resolved. Analog machines are being phased out and EWC beneficiaries are having a hard time finding providers. It would cost the EWC program \$2.3 million more to screen all their beneficiaries with digital vs. analog, i.e. \$70 vs. \$133 under Medi-Cal rates.

The CRS was previously successful in urging the Medi-Cal program to not only cover digital screening but to also include a higher payment for digital.

Last year the CRS supported AB 2887 which would have required EWC to cover digital mammography and pay a differential. The bill failed to pass the Assembly Appropriations Committee due to the increased costs and the lack of state funds for any program enhancements. The CRS met with EWC program officials last October to try and find a solution. The problem is becoming more acute as more radiology groups are phasing out analog units. We have stated that radiologists can't be put in the position of miss-coding the service they provide, e.g. bill for analog and perform digital, and that we can't absorb the cost of this new technology in a screening modality that has its other challenges.

There are multiple issues with the EWC program:

Current statute requires EWC to reimburse for services according to the Medi-Cal fee schedule. Thus if EWC chose to reimburse digital screening at the analog rate they would be in violation of statute.

The EWC gets the bulk of its funding from an unallocated tobacco tax fund. If we tried to get a larger contribution to EWC to pay for the higher costs of digital, those funds would have to be taken from another program recipient.

We have told the EWC program that we do not want to place radiologists in the untenable position of missing the service they provide, i.e. provide digital but bill for analog, and risk being accused of fraud and abuse in an effort to help these women be screened.

This year AB 369 (Nava) was introduced to try and deal with issue, but solution is unclear since money is the problem and increased funding is unlikely. AB 369 is currently on the Governor's desk awaiting his signature. The bill allows the EWC program to pay providers of digital mammography at the analog rate if the provider is willing to accept that lower rate. This solution relies upon the generosity and goodwill of mammography providers to provide this valuable screening service. It is not a real solution and will likely be revisited in the next session. This is yet another example of a well intentioned program that can't accomplish its goals without adequate funding.

Funds to be Available to All Physicians for Health Information Technology

The 2009 federal economic stimulus package includes \$19 billion for health information technology (HIT), the vast majority of which will be directed to physicians to subsidize the purchase and usage of Electronic Health Records (EHR) systems. Beginning in 2011, qualifying Medicare providers stand to receive up to \$44,000 under the program; qualifying Medi-Cal providers stand to receive as much as \$65,000. These funds are predicated on physicians using EHRs, so practices and groups that already have purchased EHR systems can also qualify for funds. The CMA has made available some background information and tools applicable to all physicians.

Please visit the site here: www.cmanet.org/hit/.

Bills to Allow District Hospitals to Employ Physicians

Current California law prohibits hospitals from employing physicians with exceptions for some county hospitals and purely charitable institutions. This is the bar on the corporate practice of medicine intended to allow physicians to practice without interference from business interests through an employment situation. It allows the medical staff to function independently in the best interests of the patient.

Several years ago legislation was adopted to create a program for up to 20 physicians to be employed by district hospitals that met certain criteria, i.e. rural, financial operating losses, and have at least 50% Medi-Cal patient base. That pilot program also required the Medical Board of California to issue a report on the pilot, which they did last October. That report was inconclusive since the number of actual physicians employed by district hospitals under the pilot was only five.

Last year there were three bills introduced to modify the current prohibitions for either district hospitals only or all acute care hospitals. None of those bills were ultimately successful but we did support one of the bills that would have continued the current pilot with a slight level of expansion.

This year there are three new bills, AB 646 (Swanson), AB 648 (Chesbro) and SB 726 (Ashburn), introduced to either allow district hospitals to employ a limited number or any number of physicians, or to allow any acute care hospital to employ physicians. District hospitals cite the difficulty in recruiting physicians to rural and poor performing hospitals and believe that being able to employ physicians will make that easier. We oppose any change to the current prohibition except one that focuses on certain types of troubled hospitals and only expands the number of employed physicians to five. We believe so for the following reasons:

The existing prohibition is important for patients and quality of care to maintain physician independence. The real problem for some of these district hospitals is inadequate reimbursement from Medi-Cal and others that does not provide sufficient practice revenue to allow a physician to practice. Some hospital based specialties like radiology and pathology need a group practice in order to provide adequate hospital coverage. Hiring individual physicians will not solve that issue.

Both AB 646 and 648 did pass the Assembly but did not pass their initial Committee hearings in the Senate Business and Professions Committee and thus have become two year bills, meaning they can be taken up next year and are alive.

In the meantime SB 726 was substantially amended in the Senate Committees prior to its passage by the Senate. It would have limited the total number of physicians that could be employed by district hospitals to 20 statewide, no more than two per hospital, after their was proof of the inability of the hospital to recruit that type of physician for at least 1 year. It would have also limited the physicians who could be employed to “core” specialties such as internal medicine, surgery and ob-gyn and not radiology. With those amendments SB 726 passed the Senate over the author’s real reluctance to accept these restrictive amendments. The CMA thought this was a reasonable compromise and the CRS agreed with that assessment.

When SB 726 was heard in the Assembly Health Committee there were amendments to delete the restrictions and limits on the number of physicians who could be employed and the “core specialties limitation. It would allow employment of physicians by both district and rural hospitals. Organized medicine now opposes the amended SB 726. It is on the Assembly floor and becomes a two year bill. This issue will continue since the need to change the employment restriction is strongly supported by district hospitals, the California Hospital Association, unions, and a growing number of individual physicians who are testifying at hearings that they want to be employed for economic security.

There is no doubt that some district and many rural hospitals do have problems in recruiting physicians. Many of these hospitals have a large census of Medi-Cal and Medicare patients which result in lower revenues for both hospitals and physicians and financial stability problems. Providing greater autonomy to hospitals by allowing them to employ physicians is not the answer.

II. REGULATORY

Medicare CAC Committee

The CRS is very fortunate to have the dedication and participation of Drs. Mark Alson and Mark Yeh in the Medicare Carrier Advisory Committee process conducted by our California Part B carrier Palmetto. They attend the quarterly advisory committee meetings and provide input on issues affecting the radiology community. We also maintain active liaison with Palmetto staff to assist members with provider enrollment and reimbursement issues.

Palmetto Audits of Medicare Chest X-Ray Payments

We have heard from multiple groups complaining about a high volume of audit letters from Palmetto on claims paid for chest x-rays in the period August through November of 2008.

Starting in July, radiology groups have received ADR letters requesting medical documentation on chest films, CPT 71010 and 71020. Some groups have received literally thousands of individual ADR letters for each specific claim for the period of August through October. Some groups say that it represents 50% of the claims but depending upon the ability or willingness to reach someone in Palmetto sometimes it goes down to 25% of the claims or some other percentage. This is a statewide audit and the numbers are staggering.

Needless to say it has taken a significant amount of paperwork and staff time to respond to these ADRs. The documentation for these hospital patients is maintained by the hospital. Hospital records department employees are typically not clinicians and are not able or willing to pull out the specific documents requested from a patient's file.

The CRS has contacted Palmetto and complained about the specifics of this audit technique and the magnitude of the volume of the claims. Radiology groups are concerned that these payments might be recouped if they don't respond in the 30 day period.

The reason for this approach may involve concerns from Palmetto that they may be reimbursing both radiologists and their ER physicians for the interpretation of chest X-rays. Many years ago Medicare established a policy that defines who should be paid and under what conditions. This policy should obviate the need for this kind of audit. As of this writing we are awaiting their response and will share information via *CAL-RAD Facts*.

Radiologic Technology Certification Committee/ Radiology Assistants

The RTCC is an advisory committee to the Bureau of Radiologic Health that provides guidance on issues related to licensing, certification, and education of users of ionizing radiology. The CRWS has been ably represented by Drs. Roger Eng, Bernie Goler and John Go who have served on the RTCC and attend meetings twice per year.

The CRS has previously proposed legislation to create the new license category for radiology assistants in California. We have not been able to pass these bills largely due to the dismal state budget situation and the inability to create any new programs or initiatives due to the new costs. The CRS has asked via the RTCC to encourage the Bureau to explore how those possible costs could be minimized to clear the way for passage of legislation. Those conversations are continuing and we will evaluate the prospect of legislation again next year.

FTC Says Physicians Must Comply with "Red Flag" Identity Theft Rules *New November 1 Deadline*

The Federal Trade Commission's "Red Flag Rules" require financial institutions and "creditors" to develop and implement identity theft detection and prevention programs by May 1, 2009. Despite objections from CMA, AMA, and others in organized medicine, the FTC insists that physicians who regularly bill their patients for services (including co-payments and coinsurance) are considered "creditors" and must develop and implement written identity theft prevention programs for their practices originally by May 1, 2009 deadline. That deadline has been delayed twice and is currently delayed until November 1, 2009.

The original purpose of these regulations was aimed at financial institutions and based upon objections from physicians and others. The regulation implementation was delayed last year.

CMA and AMA continue to urge the FTC to reconsider its interpretation of physicians as "creditors." CMA believes the Red Flag Rules could impose an unnecessary burden on physician practices, which often already operate under severely strained conditions. CMA also believes the new rules are unnecessary for most physicians because the Health Insurance Portability and Accountability Act (HIPAA) imposes strict requirements to safeguard the confidentiality and security of electronic patient information. Physicians should begin to plan their compliance programs until further notice.

CMA is also preparing a written toolkit to help physicians develop and implement identity theft detection programs. The toolkit will be posted on the CMA website as soon as it is completed.

III. CRS NOMINATING COMMITTEE REPORT

The Nominating Committee of the California Radiological Society has recommended the following individuals for 2009 - 2010 Officers:

President	Mark Alson, MD
President - Elect	Nancy Ellerbroek, MD, FACR
Secretary	Michael Puckett, MD
Treasurer	Vivian W. Wing, MD

These nominations will be considered during our Annual Meeting on Sunday, October 25, 2009, during the Business Meeting at the Hyatt Regency in Newport Beach, CA.

IV. MEMBERSHIP SERVICES

CRS maintains the tradition of providing valuable services to its members with our quarterly bulletins, e-mail broadcasts and website to communicate with members. Our thanks to Dr. Michael Puckett for his work as program chair for this year's Annual Meeting.

CRS membership currently consists of 1,159 radiologist members, 529 retired members, 24 physicists, 80 residents, for a total membership count of 1,792. CRS currently has 21 Councilors and Alternates to the American College of Radiology.

V. FINANCIAL REPORT

The accountant's review and year-end financial statement for the fiscal year ending December 31, 2008 showed cash of \$170,651 and prepaid expenses of \$15,375 for total assets of \$186,026. In 2008 CRS had income of \$194,687 and operating expenses of \$241,479 for a loss of \$46,792. The unrestricted General Fund is \$46,183 for the beginning of 2009.

VI. CONCLUSION

I am grateful to CRS Officers and the Executive Committee for their dedication and support this past year. Your support and participation now and in the future will continue our efforts to strengthen the voice of Radiology and foster greater knowledge and understanding in your field.

Respectfully submitted,



Robert Achermann
Executive Director